

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/23/2010
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		Maysville Nursing and Rehabilitation Facility does not believe nor does the facility admit that any deficiencies exist.	
F 281 SS=D	<p>A Recertification and an Abbreviated Survey related to ARO KY15015 was conducted 09/21/10 through 09/23/10, and a Life Safety Code Survey was conducted 09/23/10. Deficiencies were cited with the highest Scope and Severity of a "E". ARO KY15015 was unsubstantiated with no deficiencies cited.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure services provided met professional standards for two (2) of twenty-four (24) sampled residents (Resident #14 and #6). Resident #14 was observed to be receiving oxygen per nasal cannula without a Physician's order. Resident #6 was order to have an annual chest x-ray, related to having a history of a positive PPD. However, the facility administered the PPD test instead of obtaining the Chest X-ray, which was ordered.</p> <p>The findings include:</p> <p>Review of the facility "Physician's Orders" Policy revealed "all medications administered to the resident must be ordered, in writing, by the resident's attending physician. Medications, diets, therapy, or any other treatment may not be administered to the resident without the written approval from the attending physician".</p>	F 281	<p>Maysville Nursing and Rehabilitation Facility reserves all rights to contest the survey findings through informal dispute resolution, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Maysville Nursing and Rehabilitation Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Maysville Nursing and Rehabilitation Facility does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Maysville Nursing and Rehabilitation Facility offers its responses, credible allegations of compliance and plan of correction as</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Cortney Burkhardt

TITLE

RJ, BSN, LNAHA

(X6) DATE

11/4/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 1. Review of Resident #14's medical record revealed diagnoses which included Dementia, and Congestive Heart Failure. Further record review revealed the Admission Minimum Data Set (MDS) had not been completed due to the recent admission. Observation on 09/21/10 at 1:00 PM revealed Resident #14 was watching television and had oxygen per nasal cannula at three (3) liters in place. Further observation of the resident on 09/22/10 at 11:00 AM revealed the resident was in the bed with oxygen per nasal cannula at 3 liters in place. Review of the Admission Physician's Orders dated 09/17/10 and review of the Physician's Orders from 09/17/10 through 09/21/10 revealed there were no Orders for oxygen. Interview on 09/23/10 with Registered Nurse (RN) #3, revealed the resident was transferred to the hospital on 09/16/10 and returned on 09/17/10. She further stated the orders for oxygen were not reordered when the resident was re-admitted to the facility on 09/17/10. She stated she had notified the Physician there were no current Orders for oxygen for Resident #14 the morning of 09/23/10, and obtained Physician's Orders for oxygen at two (2) liters per nasal cannula prn (as needed) for shortness of breath. 2. Review of the clinical record revealed Resident #6 had diagnoses which included Positive Purified Protein Derivative (+PPD), Chronic Obstructive Pulmonary Disease and Dementia.	F 281	part of its on-going effort to provide quality care to residents. Maysville Nursing and Rehabilitation Facility strives to provide the highest quality care while ensuring the rights and safety of all residents. F281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility to ensure services are provided and arranged by the facility and that the services meet professional standards. Resident #14 had been readmitted to Maysville Nursing and Rehabilitation Facility on 9-19-10. Resident #14 had an order for oxygen on her original admission and this was a simple transcription error upon return from the hospital. 1. Resident #14 now has an oxygen order for 2L prn. There had been an order in place upon admission. The resident was hospitalized and upon return the MD failed to reorder the oxygen and the nursing staff failed to make the request. Resident #6's medical record has been flagged (+PPD) and	

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F 281

Continued From page 2

Review of the 12/30/09 Physician's Orders revealed an order for a Chest X-ray every year related to +PPD (had a +PPD test in 2003). Review of the 12/30/09 Medication Administration Record (MAR) revealed the resident received the PPD test instead of the Chest X-ray which was ordered.

Interview on 09/22/10 at 3:30 PM with the Assistant Director of Nursing revealed the nurse read the order incorrectly when the order was transcribed. She stated the resident should have had a chest X-ray, and should not have received the PPD test. Further interview revealed the facility was aware of the error, and an inservice was provided to staff on 01/11/10 related to PPD tests as a result of the error.

F 282
SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined the facility failed to implement the Plan of Care for one (1) of twenty four (24) sampled residents (Resident #2). Resident #2's Plan of Care revealed an intervention to always use a gait belt with transfers. However, on 07/09/10 the resident was transferred without the use to a gait belt, and sustained a fall.

F 281

F 282

physician was notified of the administration of PPD.

2. All residents who require oxygen have had their charts reviewed for proper oxygen orders. This audit was conducted by the Assistant Director of Nursing on 9-24-10. All resident's with positive PPD's have had their record reviewed to ensure they have not received PPD testing. This audit was conducted by the Assistant Director of Nursing on 9-24-10. All resident charts have been audited for proper implementation of MD orders by nurse conduction monthly changeover on 10-25-10, 10-26-10, and 10-27-10.
3. In-service education was conducted on 10-8-10 by the Assistant Director of Nursing and Administrator for all licensed staff (RN's and LPN's) to enforce the need to follow and obtain physician orders. Monthly the nurse conducting change over will audit all orders to ensure they match the care being provided to each resident.
4. Daily (Monday-Friday) the MDS/Assessment nurses will

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F 282	<p>Continued From page 3</p> <p>The findings include:</p> <p>Review of Resident #2's medical record revealed diagnoses which included Parkinson's Disease and Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/16/10, revealed the facility assessed the resident as having moderately impaired cognitive skills for daily decision making and as sometimes able to understand verbal information. Further review of the MDS revealed the facility assessed Resident #2 as requiring extensive assistance with transfers and as requiring physical help with balance while standing.</p> <p>Review of the Fall Risk Assessment dated 07/15/10, revealed Resident #2 had intermittent confusion, had three (3) or more falls, was chair-bound, and not able to perform gait/balance function test. Resident #2 was scored at an eighteen (18) on the Fall Risk Assessment, which placed the resident at High Risk for Falls.</p> <p>Review of the Resident Incident/Accident Follow-Up Assessment Form dated 07/09/10, revealed Resident #2 was being transferred by two (2) Certified Nursing Assistants (CNAs) and a gait belt was not being utilized as per the Comprehensive Plan of Care. The Form revealed the CNAs lost their balance while transferring causing the CNAs and the resident to fall.</p> <p>Review of the Comprehensive Care Plan, revealed an intervention was instituted to remind staff to always use a gait belt with transfers on 04/02/08. Further review of the Care Plan revealed the same intervention was re-instituted</p>	F 282	<p>monitor physician orders to ensure they are implemented as ordered and the care being given matches the orders. Assignments will be made in morning meeting (Monday-Friday) to audit order implementation. This is an ongoing process. All admission/readmission orders will be reviewed within 24 hours by the Assistant Director of Nursing to ensure the orders have been implemented appropriately.</p> <p>5. 10-28-10</p> <p>F282 483.20(k)(3)(ii) SERVICES QUALIFIED PERSONS/PER CARE PLAN</p> <p>It is and was the policy of Maysville Nursing and Rehabilitation Facility to provide services by a qualified person in accordance with each resident's plan of care.</p> <ol style="list-style-type: none"> 1. Resident #2 nursing assistant plan of care clearly states transfer with gait belt. Resident #2 is being transferred with gait belt use only. 2. All residents who require assistance with transfer have 		

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F 282	Continued From page 4 after the resident's fall on 07/09/10. Interview on 09/23/10 at 2:15 PM with Licensed Practical Nurse (LPN) #6, revealed the LPN was called to Resident #2's room by two (2) Certified Nursing Assistants (CNAs). The LPN stated, Resident #2 was found to be lying in the floor after an attempted transfer without using a gait belt. The LPN further stated, a conference was held with the two (2) CNAs regarding the use of the gait belt while transferring Resident #2. The resident sustained a skin tear to the left elbow as a result of the fall. Interview with CNA #3 on 09/23/10 at 2:17 PM, revealed a gait belt was not used during the transfer of Resident #2. CNA #3 stated, a gait belt should have been used while transferring the resident. Interview on 09/22/10 at 12:30 PM with the Assistant Director of Nursing (ADON), revealed if a resident required assistance to transfer, it was understood staff were to use a gait belt.	F 282	been reviewed to ensure they are being transferred with use of the gait belt. All care plans were reviewed by DON and MDS staff on 10-20-10 and 10-21-10 for implementation of appropriate interventions. All care plans are audited at least quarterly and will continue to be audited quarterly or with any significant changes in condition. New MD orders are reviewed daily by the DON and MDS staff and are added to the care plan. Any care issues are reviewed daily by the interdisciplinary team in morning meeting.		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure two (2) of twenty-four (24) residents	F 323	3. Five days per week the nurse aide coordinator will monitor transfers to ensure they are being conducted properly (at least 10% of all transfers will be monitored daily). All nursing staff has been inserviced by ADON on 9-24-10 and 10-8-10 related to following the care plans. 4. As part of the facility's ongoing Quality Assurance program the assistant Director of Nursing will monitor 10% of all plans of care to ensure that care is provided by a qualified person in accordance with their		

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F 323	<p>Continued From page 5</p> <p>received adequate supervision and assistive devices to prevent accidents (Resident #10 and #2). Resident #10 sustained a fall while being assisted without the use of a gait belt, which resulted in a Pelvic Fracture. Resident #2 was assisted without the use of a gait belt, which resulted in a fall. In addition, the facility failed to ensure the Beauty Shop, containing hazardous products, remained locked, and not accessible to residents, when not in use.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of Resident #10's medical record revealed diagnoses which included Dementia, Osteoporosis, Depression, and Compression Fractures of the Spine. <p>Review of the Minimum Data Set (MDS) Assessment dated 08/08/10 revealed the facility assessed Resident #10 as having moderate impairment in cognitive skills for daily decision making, as prone to Depression and Anxiety, as on psychiatric medications, and as being at risk for falls.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 08/08/10 revealed the resident triggered for cognitive impairment, mood, behaviors, and falls.</p> <p>Review of the Comprehensive Plan of Care dated 07/21/08 and revised 08/19/10, revealed the resident was at high risk for falls related to resisting care and sustaining a fall in the past thirty (30) days resulting in a Pelvic Fracture. Several interventions were in place to prevent falls; however there was no intervention to use a gait belt for transfers until 08/07/10. The Care</p>	F 323	<p>plan of care. This audit will continue for (6) six months. Monday – Friday the Assistant Director of Nursing reviews all MD orders and compares the orders to the care being provided. This process is ongoing.</p> <p>5. 10-27-10</p> <p>F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility to ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistive devices to prevent accidents.</p> <ol style="list-style-type: none"> Resident #10 had the following approaches and interventions in place to prevent falls: nonskid strips to wheelchair under cushion to prevent slipping, 15 pound weights applied to crossbars of wheelchair to prevent tipping, nonskid strips to floor by bed and recliner, and low bed. Resident #2 had the following approaches and interventions in place to prevent falls: nonskid strips to 	

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F 323	<p>Continued From page 6</p> <p>Plan was revised to include the fall which the resident sustained on 08/07/10, and an intervention which stated "staff educated gait belt to be in use during transfers."</p> <p>Review of the Resident Incident/Accident Follow Up Assessment Form revealed the resident sustained a fall on 08/07/10 at 5:00 AM while being transferred to a wheelchair. The causative factor listed was transferring without a gait belt.</p> <p>Interview with Certified Nursing Assistant (CNA) #3 on 09/22/10 at 9:30 AM, revealed she had taken the resident to be toileted on 08/07/10 and on the way back from the bathroom, the resident slipped and fell when being transferred to the wheelchair. The CNA stated she was holding the resident's hand but could not hold the resident up. Further interview, revealed "the facility had showed us how to use them (gait belts) but I didn't think about putting it back on (the resident) when I stood" the resident "back up".</p> <p>Interview with Licensed Practical Nurse (LPN) #6 on 09/22/10 at 2:45 PM revealed CNA #3 was trained on the use of the gait belt during CNA training at the facility, and should have used the gait belt to transfer Resident #10 on 08/07/10.</p> <p>Review of CNA #3's employee file, revealed the CNA had attended and signed off on a training she attended regarding using a transfer belt, transfers, and types of weight bearing precautions on 05/07/10. This training was provided by the rehabilitation department at the facility.</p> <p>Interview on 09/22/10 at 12:30 PM with the Assistant Director of Nursing (ADON), revealed if a resident required assistance to transfer, it was</p>	F 323	<p>floor beside bed, breakaway alarm while in bed and chair, and dycem to wheelchair seat under cushion. Both residents #10 and #2 have recovered from their falls. Both residents have had no further falls from August 2010 forward. All chemicals are locked up when staff is out of the beauty shop.</p> <p>2. The facility Administrator and Director of Nursing make rounds daily to ensure that all potential hazards are addressed by staff. Thorough fall risk assessment are completed on all residents upon admission, at least quarterly, or with any significant change in condition. All resident care is reviewed daily through report/report sheet with any changes discussed in morning meeting with interdisciplinary team. Devices, such as alarms are implemented as necessary. All resident care plans were reviewed by DON and MDS staff on 10-20-10 and 10-21-10 to ensure necessary interventions are in place to prevent accidents. All resident care plans are reviewed by DON and MDS staff at least quarterly.</p>	

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F 323	<p>Continued From page 7</p> <p>understood staff were to use a gait belt.</p> <p>2. Review of Resident #2's medical record revealed diagnoses which included Parkinson's Disease and Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/16/10, revealed the facility assessed the resident to have moderate impairment with cognitive skills for daily decision making. Further review of the MDS, revealed the facility assessed the resident as requiring extensive assistance with transfers and as having functional limitation to both legs.</p> <p>Review of the Resident Accident/Incident Report dated 07/07/10 at 2:30 PM, revealed LPN #6 was called to Resident #2's room when the Resident fell during a transfer. The Report revealed Resident #2 sustained a skin tear to the left elbow during the fall. Further review of the Report, revealed the CNA's were not using a gait belt with the transfer.</p> <p>Review of the Comprehensive Plan of Care, revealed the Care Plan had been revised on 04/02/08 with an intervention to ensure a gait belt was used while transferring Resident #2.</p> <p>Interview with Licensed Practical Nurse (LPN) #6 on 09/23/10 at 2:15 PM, revealed the LPN was called to Resident #2's room on 07/09/10 and the resident was noted to be lying on the floor. Further interview with LPN #6, revealed after Resident #2 sustained the fall, a conference was held with the CNAs regarding transfers and the use of gait belts with Resident #2.</p> <p>Interview with Certified Nursing Assistant (CNA) #3 on 09/23/10 at 2:17 PM, revealed a gait belt</p>	F 323	<p>3. In-service education was conducted on 9-22, 9-24, and 10-8-10 discussing use of gait belt and other safety issues. This in-service was conducted by the Assistant Director of Nursing for all nursing staff. Monday-Friday, a member of the safety Committee will audit the facility for any accident hazards. The charge nurse on each unit will be responsible for monitoring the nursing staff to ensure that assistive devices and supervision is in place to prevent accidents. A discussion was held with the beautician concerning locking chemicals when out of the shop on 9-24-10.</p> <p>4. As part of the facility's ongoing Quality Assurance program a member of the safety committee will Monday-Friday make safety rounds through out the facility. Any potential hazards will reported immediately to the Administrator. In addition the Director of Nursing or Assistant Director of Nursing will observe at least ten unannounced transfers per month. The beauty shop will be reviewed at least six times a</p>		

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F 323	Continued From page 8 was not used to transfer Resident #2 when the resident fell on 07/09/10. Further interview with the CNA, revealed a gait belt should have been used while transferring Resident #2. Interview with the Assistant Director of Nursing (ADON) on 09/22/10 at 12:30 PM, revealed it was understood staff were to use a gait belt with transfers for residents who required assistance or were over one hundred (100) pounds. 3. Observation on initial tour on 09/21/10 at 11:15 AM revealed the Beauty Shop door was open and unattended. A container of Barbicide was noted to be on the counter beside the sink. Interview on 09/23/10 at 4:30 PM with the Administrator revealed it was not a requirement to lock the Beauty Shop door for five minutes to go get a resident. However, the Beauty Shop was to be locked at the end of the day. Further interview revealed there were some wandering residents who may wander down the hall where the Beauty Shop was located. Review of the Material Safety Data Sheet for Barbicide revealed; prolonged inhalation exposure may cause nausea, dizziness or disorientation, avoid ingestion and eye contact, and keep out of the reach of children. Further review of the MSDS revealed ingestion of greater than fifty (50) milliliters could cause circulatory shock, seek medical attention immediately.	F 323	month when the beautician is out of the room to ensure chemicals are secured. 5. 10-21-10		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS Resident #17 had a knee replacement and a MRSA infection, which was identified, and being treated appropriately. The infection control manual stated, "Contact isolation may be considered." Body substance isolation is used routinely in this facility. It is the policy of Maysville Nursing and Rehabilitation Facility maintains an effective infection control program in order to prevent the development and transmission of disease. 1. Contact isolation has been initiated for resident #17. 2. No other residents have been affected. The facility has monitored all infections to ensure no other residents have been infected. No other cases of MRSA have been noted on		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/23/2010
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 9</p> <p>to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility.</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain an effective infection control program in</p>	F 441	<p>the South wing of the facility from 9-23-10 to present. The facility monitors infections monthly in conjunction with out labs.</p> <p>3. An in-service was held on 9-22-10, 9-24-10, and 10-8-10 with all licensed staff related to infection practices. This was conducted by the Assistant Director of Nursing. Infection control reports (lab listing) and practices (direct observation) will be reviewed by the Assistant Director of Nursing at least once per week on varying shifts to ensure compliance with policies and procedures.</p> <p>4. As part of the facility's ongoing Quality Assurance program the Administrator will at least monthly observe infection control practices (handwashing, isolation, etc) to ensure all policies and procedures are being followed. These observation will become part of the CQI meeting monthly.</p> <p>5. 10-10-10</p>		

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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
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F 441	<p>Continued From page 10</p> <p>order to prevent the development and transmission of disease and infection within the facility for one (1) of twenty-four (24) sampled residents (Resident #17).</p> <p>The findings include:</p> <p>Review of the facility "Infection Control Manual; Contact Precautions" revealed it was the intent of the facility to use Contact Precautions in addition to Standard Precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment. The Manual stated Contact Precautions may be considered for MRSA. The Manual further stated the resident may be placed in a private room or if a private room was not needed or available, placed in a room with a resident who had an active infection with the same organism. Gloves should be worn when entering the room and while providing care for the resident, gloves should be changed after having contact with infective material, gloves should be removed before leaving the resident's room and hand hygiene performed immediately. A gown should be worn when entering the room if it was anticipated clothing would have substantial contact with the resident, environmental surfaces, or items in the resident's room, or if the patient was incontinent or had wound drainage which was not contained by a dressing.</p> <p>1. Review of Resident #17's medical record revealed diagnoses which included Right Total Knee Replacement with Wound Dehiscence and Infection, Right Knee Arthroplasty, and Methicillin Resistant Staph Aureus (MRSA) Right Knee.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 820 PARKER ROAD MAYSVILLE, KY 41056		
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F 441	<p>Continued From page 11</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment dated 08/23/10 revealed the facility assessed the resident as having modified independence in cognitive skills for decision making. Further review of the MDS revealed the facility assessed the resident as requiring extensive to total assistance with transfers, ambulation, dressing, hygiene, and bathing.</p> <p>Review of the Resident Assessment Protocol Summary dated 08/23/10 revealed the resident was diagnosed with "Redo Flushout" of the Right Knee, and the Right Knee surgical site was to be covered with a dressing.</p> <p>Review of the Plan of Care dated 08/25/10 revealed the resident had infection with a goal which stated the infection would resolve. The interventions included Vancomycin intravenously as ordered.</p> <p>Review of the Hospital Discharge Summary dated 09/03/10 revealed the resident had been re-admitted to the hospital for cleanup of the right knee. Further review of the Summary revealed the culture grew MRSA and the resident was treated with Vancomycin (antibiotic medication).</p> <p>Review of the Physician's Progress Notes dated 09/15/10 revealed a section labeled assessment which stated the resident had a total Knee Replacement and MRSA of the Right Knee, and was receiving intravenous (IV) Vancomycin.</p> <p>Review of the Physician's Orders dated 09/03/10 revealed Orders for Vancomycin one (1) gram every twelve (12) hours per intravenous PICC line. Review of the Physician's Orders dated 09/04/10 revealed orders for Vancomycin 1.5 grams every</p>	F 441			

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F 441	<p>Continued From page 12</p> <p>day per IV PICC line. Further review of Physician's Orders dated 09/13/10 revealed Orders for Vancomycin IV 1750 milligrams daily at noon. Review of the Physician's Orders dated 09/16/10 revealed orders to continue the same dose of Vancomycin 1750 milligrams.</p> <p>Observation of Resident #17 on 09/21/10 at 10:15 AM revealed the resident was in a wheelchair being pushed by staff down the hall. Observation of the resident on 09/23/10 at 9:00 AM and 11:00 AM revealed the resident was in his/her private room sitting in a wheelchair.</p> <p>Further observation throughout the survey from 09/21/10 through 09/23/10 revealed there was no signage on the resident's door and no isolation cart in the hall next to the resident's room.</p> <p>Interview with the resident on 09/23/10 at 11:00 AM revealed he/she had a Total Knee Replacement of the Right Knee, and the knee became infected. He stated at times there was a lot of drainage on the dressing and the drainage would also seep out to his/her pant leg.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, who was assigned to the resident, revealed the resident had a Total Knee Replacement and was receiving dressing changes to the Right Knee and IV antibiotics due to MRSA of the Knee. Further interview revealed the staff were using Standard Universal Precautions. She further stated the staff were not using Contact Precautions which would include gloves and a gown due to the wound being covered with a dressing. However, she further stated the resident sometimes had drainage from the dressing which would come out on the resident's clothes.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
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F 441	Continued From page 13 Interview on 09/23/10 at 5:10 PM with the Infection Control Nurse, revealed she reviewed Physician's Orders daily as well as labs and cultures. She further stated the facility used the "Infection Control Manual" recommendations in deciding what type of precautions to use related to infections. She stated all the residents were treated with Standard Precautions unless there was a need for Isolation. Further interview revealed Contact Precautions were not needed for Resident #17 due to the wound was covered with a dressing and contained.	F 441			

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K 000	INITIAL COMMENTS A Life Safety Code Survey was initiated and concluded on 09/23/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "D".	K 000	Maysville Nursing and Rehabilitation Facility does not believe nor does the facility admit that any deficiencies exist.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the facility's sprinkler system was maintained according to NFPA standards. The findings include: Observation on 09/23/2010 at 9:16 AM, revealed that in the laundry room behind the dryers, there was a sprinkler head mounted in an improper position. The sprinkler head was marked as an upright sprinkler head but was mounted in a	K 056	Maysville Nursing and Rehabilitation Facility reserves all rights to contest the survey findings through informal dispute resolution, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Maysville Nursing and Rehabilitation Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Maysville Nursing and Rehabilitation Facility does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Maysville Nursing and Rehabilitation Facility offers its responses, credible allegations of compliance and plan of correction as	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Cornelius Burkhardt

TITLE

RN/BSN/LN/HA

(X6) DATE

11/4/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 056	Continued From page 1 pendent position. The observation was confirmed with the Maintenance Director. Interview on 09/23/2010 at 9:16 AM, with the Maintenance Director, revealed he depended on an outside company to inspect and maintain the sprinkler system. Reference: NFPA 25 (1998 edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. NFPA 101 LIFE SAFETY CODE STANDARD	K 056	part of its on-going effort to provide quality care to residents. Maysville Nursing and Rehabilitation Facility strives to provide the highest quality care while ensuring the rights and safety of all residents. K056 NFPA 101 LIFE SAFETY CODE STANDARD It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility that the facility sprinkler system be maintained according to NFPA standards. 1. The sprinkler head in question has been replaced with a 1.55 pendant chrome standard response sprinkler head correctly. 2. All sprinkler heads have been audited to ensure they are appropriately mounted. 3. Discussion with the outside contractor and the administrator of the facility concerning expectations during scheduled visits and reports. 4. As part of the facility's ongoing Quality Assurance program the Director of Maintenance will annually review all sprinkler head positioning independent of the		
K 070 SS=D	Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8	K 070			

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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 520 PARKER ROAD MAYSVILLE, KY 41056
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K 070	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure portable space heaters were approved according to NFPA standards. The findings include: Observation of the Administrator's office on 09/23/2010 at 1:34 PM, revealed a space heater. The observation was confirmed with the Administrator. When asked about the heater the facility could not produce any documentation stating the heater was approved for use in a Health Care Facilities.	K 070	outside contractor to ensure proper mounting. 5. 10-11-10 K070 NFPA 101 LIFE SAFETY CODE STANDARD It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility that portable space heaters be approved according the NFPA standards.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the Oxygen Supply room was protected according to NFPA standards.	K 076	1. The heater was removed on the day of the survey although paperwork was supplied to surveyor explaining the safety features of the heater. 2. The heater was not plugged in or in use at the time of the survey. 3. All department supervisors have been educated on 9-24-10 on the use of space heaters and approval must be met by NFPA standards 4. As part of the facility's ongoing Quality Assurance program the maintenance director will inspect any space heater for NFPA standards. All rooms/offices will be inspected quarterly for the use of proper heating devices. 5. 10-11-10	

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K 076	<p>Continued From page 3</p> <p>The findings include:</p> <p>Observation of the facility's Oxygen Supply room on 09/23/2010 at 9:31 AM, revealed combustible materials, which included paper and plastic, were located approximately two and one-half (2 1/2) feet within the oxygen cylinders. The observation was confirmed with the Maintenance Director.</p> <p>Interview with the Maintenance Director on 09/23/2010 at 9:31 AM, revealed the Maintenance Director was unaware that combustible materials could not be stored within five(5) feet of oxygen cylinders.</p> <p>Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection</p>	K 076	<p>K076 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>The oxygen supply room held 10-12 oxygen tanks and several (4-6) empty tanks, which were separated in (2) racks. There were plastics stored above the tanks on a separate shelf approximately 2-3 feet away.</p> <ol style="list-style-type: none"> 1. The oxygen supplies have been moved to another storage room. 2. All combustibles have been placed at least five feet above the oxygen storage. 3. An in-service was held with all licensed staff (RN's and LPN's) by ADON to inform them of the above practice on 10-8-10. 4. As part of the facility's on going Quality Assurance 	

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K 076	Continued From page 4 rating of 1/2 hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076	program the Director of Maintenance will check the supply room at least weekly. 5. 10-11-10		

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K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the facility's sprinkler system was maintained according to NFPA standards. The findings include: Observation on 09/23/2010 at 9:16 AM, revealed that in the laundry room behind the dryers, there was a sprinkler head mounted in an improper position. The sprinkler head was marked as an upright sprinkler head but was mounted in a	K 056	Maysville Nursing and Rehabilitation Facility reserves all rights to contest the survey findings through informal dispute resolution, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Maysville Nursing and Rehabilitation Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Maysville Nursing and Rehabilitation Facility does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Maysville Nursing and Rehabilitation Facility offers its responses, credible allegations of compliance and plan of correction as	

RECEIVED
OCT 28 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Courtney Burkhardt</i>	TITLE <i>RN,BSN,LNHA</i>	(X6) DATE <i>10/28/10</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/23/2010
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
K 056	Continued From page 1 pendent position. The observation was confirmed with the Maintenance Director. Interview on 09/23/2010 at 9:16 AM, with the Maintenance Director, revealed he depended on an outside company to inspect and maintain the sprinkler system. Reference: NFPA 25 (1998 edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 056	part of its on-going effort to provide quality care to residents. Maysville Nursing and Rehabilitation Facility strives to provide the highest quality care while ensuring the rights and safety of all residents. K056 NFPA 101 LIFE SAFETY CODE STANDARD It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility that the facility sprinkler system be maintained according to NFPA standards. 1. The sprinkler head in question has been replaced with a 155 pendant chrome standard response sprinkler head, correctly. 2. All sprinkler heads have been audited to ensure they are appropriately mounted. 3. Discussion with the outside contractor and the administrator of the facility concerning expectations during scheduled visits and reports. 4. As part of the facility's ongoing Quality Assurance program the Director of Maintenance will annually review all sprinkler head positioning independent of the		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8	K 070			

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K 070	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure portable space heaters were approved according to NFPA standards. The findings include: Observation of the Administrator's office on 09/23/2010 at 1:34 PM, revealed a space heater. The observation was confirmed with the Administrator. When asked about the heater the facility could not produce any documentation stating the heater was approved for use in a Health Care Facilities.	K 070	outside contractor to ensure proper mounting. 5. 10-11-10 K070 NFPA 101 LIFE SAFETY CODE STANDARD It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility that portable space heaters be approved according the NFPA standards.		
K 076 SS-D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the Oxygen Supply room was protected according to NFPA standards.	K 076	<ol style="list-style-type: none"> 1. The heater was removed on the day of the survey although paperwork was supplied to surveyor explaining the safety features of the heater. 2. The heater was not plugged in or in use at the time of the survey. 3. All department supervisors have been educated on 9-24-10 on the use of space heaters and approval must be met by NFPA standards 4. As part of the facility's ongoing Quality Assurance program the maintenance director will inspect any space heater for NFPA standards. All rooms/offices will be inspected quarterly for the use of proper heating devices. 5. 10-11-10 		

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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
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K 076	<p>Continued From page 3</p> <p>The findings include:</p> <p>Observation of the facility's Oxygen Supply room on 09/23/2010 at 9:31 AM, revealed combustible materials, which included paper and plastic, were located approximately two and one-half (2 1/2) feet within the oxygen cylinders. The observation was confirmed with the Maintenance Director.</p> <p>Interview with the Maintenance Director on 09/23/2010 at 9:31 AM, revealed the Maintenance Director was unaware that combustible materials could not be stored within five(5) feet of oxygen cylinders.</p> <p>Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection</p>	K 076	<p>K076 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>The oxygen supply room held 10-12 oxygen tanks and several (4-6) empty tanks, which were separated in (2) racks. There were plastics stored above the tanks on a separate shelf approximately 2-3 feet away.</p> <ol style="list-style-type: none"> 1. The oxygen supplies have been moved to another storage room. 2. All combustibles have been placed at least five feet above the oxygen storage. 3. An in-service was held with all licensed staff (RN's and LPN's) by ADON to inform them of the above practice on 10-8-10. 4. As part of the facility's on going Quality Assurance 		

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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 820 PARKER ROAD MAYSVILLE, KY 41056		
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K 076	Continued From page 4 rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076	program the Director of Maintenance will check the supply room at least weekly. 5. 10-11-10		